Commentary on the Keynote Address

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In my reactions to the keynote address at the Margaret E. Mahoney Symposium, I chose to take the charge about predicting the future of managed care somewhat literally: I actually made predictions about the future of managed care. I took one precaution, however, at the symposium: I did not show any slides, so that there would be no permanent evidence of those predictions. This issue of the *Bulletin* complicates my life somewhat, because now there is a public record, but I take comfort in the knowledge that this is a notoriously difficult area. I have, after all, looked for wisdom in other areas of endeavor. I first looked to Jack Welch, the CEO of General Electric, who is always right and who is, everyone assumes, one of the world's greatest CEO's. His words about the future were, "I've given up trying to predict the future; I'm just going to try and react faster than anybody else to the present." That wasn't satisfying, so I went even further afield, to literature. I like Somerset Maugham. Once, he was talking about what makes a good writer. He said, "There are three basic rules to making a good writer. When you know those rules you'll be a good writer. The trouble is, nobody knows what they are."

That's my feeling about trying to predict what's going to happen in a market environment. By their very natures, markets are messy. We all are aware that we tried for universal coverage and we failed. Unfortunately, we are left with a market for correction; that is always difficult, and hopefully, not permanent.

Nevertheless, if one considers the future of managed care right

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now, one has to look at market dynamics. I will discuss some of the things that I think are going to be critical for the future.

The first is that management is probably more critical in a market environment than it is in a regulated environment. If there's truth to be learned in our history, it is that a little bit of regulation does not control health care. It takes a great deal of regulation. Right now, we don't have an appetite for that, so the alternative is a management-intensive environment.

Second, with the exception, perhaps, of capital (and I would argue that the current market in for-profit health care is inefficient), the current market is not doing what markets should do, which is rewarding strictly value. When a company that has a 20:1 PE ratio buys a company of the same size that has 10:1 PE ratio and the PE ratio goes to 30, that is not an efficient market. That happens all too often in this market, however.

With the single exception of access to capital, which will, I think, change over time, the advantages of the for-profit market will not be as great as the not-for-profit market. I predict that there is not going to be a lot of difference between types of managed-care companies and their success in the future. So for all kinds of managed-care organizations—IPAs, staff models, for-profits, not-for-profits—success is going to be related much more to the quality of their management than it is going to be related to the style or type of company, or to their tax status.

Clearly, regulation is critical in a market economy. We can use the New York example as part of that. It takes a different kind of regulation than we have in a regulated economy: the totally unrestricted market clearly does not work for health care. It does not provide for critical services like graduate medical education. It does little to solve the problem of the uninsured. Because we have decided not to have a regulated market, we are probably stuck with a system that does not, in the interim, solve the problem of the uninsured, and will not by itself solve the problem of graduate medical education and research. Attempts at regulating the marketplace are required if want to address those problems.

In New York State, the Governor's managed-care bill of rights

actually got a reasonably positive editorial in the *New York Times*. Like most compromises, none of the parties who worked on the bill like it in its entirety, but it is probably a sign of where we are going in the future. It clearly starts to break down the traditionally rigid gatekeeper system and defines in law several concepts, such as "emergency," that have never been defined in law before. I predict similar legislation about how we pay for drugs and determine which drugs and which procedures are experimental. That is critical for a market environment. Some kind of public- /private-sector compromise or cooperation is critical for market environment if it is to work.

Indemnity insurance will always be here. As long as we have a private-sector economy, the rich will always have access to health care that is different than the care the middle class gets. The poor will still need care.

The present gatekeeper phenomenon is a blunt instrument to solve the problem of costs. It is not liked by physicians and definitely not liked by members. The plans that control costs and get away from the gatekeeper will have a distinct market advantage. I predict many variations on efforts to do that in the future.

Access to data and information in a market environment is much more critical than in the regulated environment. You need the data to make decisions. Markets tend to make costs very explicit because private people will have to pay for them with their own money, not with taxpayers' money. I do not think that we will see an explosion of clinical data—and in the ability to transmit it—in the next few years. This has been a very frustrating area for people who have worked in it, but very slowly our various streams of clinical data are becoming standardized, so very mundane things, such as how we transmit data on laboratory results and drugs and clinical diagnoses, are starting to be standardized. In fact, I think you will see a major attempt to connect physician offices in New York State in the near future, with a standard clinical data system. This will require much cooperation among the carriers, something we have not seen before.

A New York State law, not very well known, says that in October 1995 physicians are supposed to transmit claims electronically. I am

sure that will be ignored for several years. But at some point, once we have electronic claims transmission from physicians' offices, we will have an enormous amount of data transmission from those offices and we will see the kind of information explosion and efficiencies that happened in the banking system. The advantages of this, in terms of efficiency, are really quite large and, I think, unappreciated. It will be possible for people to control their own medical records and to forward them to providers of their choice if they wish to do that. The ability to transmit information back and forth from different sites of care will lead to much-improved patient care and much-improved economy of care.

The nation is developing distinct delivery systems, a process that has many implications for a city with as many academic medical centers as does New York. New York City has very few multi-specialty practices. The likelihood that New York City will follow the California model probably is slim; I think our delivery systems will be dominated by hospitals, partly because, in the main, we don't have multi-specialty groups that aren't associated with hospitals. Our universities tend to be private rather than public and have the ability, therefore, to act more quickly in the marketplace. In a marketplace where a surplus of specialists and a surplus of hospital beds exist, even if some carrier had all of the business one still could not keep the providers working at adequate capacity. It is the business of hospitals and networks of doctors not just to get their fair share, because that is not enough in a marketplace where there is a surplus of beds and doctors, but to get their unfair share, to take business away from other networks. I think it is inevitable that we will see the formation of distinct delivery systems that compete with each other, for good or bad.

The electronic passage of information will make possible a substantial increase in medical fraud. You can cheat people more quickly with electronic information. We will see explosions of problems with medical fraud and counterefforts to deal with it. I would not be surprised if special courts arise, to deal with medical fraud.

Finally, to comment on Uwe Reinhardt's remarks, I am not quite as pessimistic as he is, although this is certainly not an

optimistic time. If one takes the perspective of the American in *Mr. Smith Goes to Washington*, which is what Uwe refers to, I think, in terms of his statement of American values, he might say something as follows: "This is a rich country and we're willing to spend a lot of money on health care, on the one hand. On the other hand, doing things that are unnecessary in terms of health care is not only unnecessarily costly, but dangerous to the patient." There is a legitimate effort to try to control costs, especially for procedures and tests that are unnecessary. Two, "We can't get universal coverage because we can't afford it." I guess Mr. Smith might say that we need to control costs. I think we will be more successful in that than Uwe might feel, although I doubt that we will ever get to the levels of other industrialized nations.

If the government can get out of taking risks for the costs of health care, if the government can actually say that we are going to increase the amount of money we spend on health care by 4% a year for the next ten years and that we will have to figure out how to do that (that has many down sides and is very dangerous), we will have the political ability to say that we should expand coverage and do what we really ought to do in this country for the uninsured and for everybody.

I would not be surprised if just that happens, even though I don't know if it is the intent of anyone doing those things to make us move toward universal coverage. If it does happen, I would not be surprised if it came from the Republicans. Politically, it would be a very powerful thing to do, akin to Nixon going to China.

In the end, therefore, I would be more optimistic for the next 5 years than Uwe would, but not that much. We are moving in a very weird way into this area of managed competition.

That is my synthesis of where we are going in this country. We ought to move faster and we ought to do it better. I suggest that we embrace the managed-competition movement because I do not think that we will go to a regulated health-care system. We should embrace that movement and try to make it work rather than try to beat it. I think we're beyond that.